DEPARTMENT OF HEALTH AND H AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th Leg. 7/11

PRINTED: 05/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44A114	A. BUILDING _____ B. WING _____	05/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE HEARTLAND	3025 FERNBROOK LANE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual Recertification survey, Complaint investigation #26139, #26877, and #27880, were completed on May 3-5, 2011, at Lakeshore Heartland. No deficiencies were cited related to Complaint investigation #26139 and #26877. Deficiencies were cited related to Complaint investigation #27880 under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility documentation, and interviews, the facility failed to report to the state agency an injury of unknown origin for one resident (#7) of fifteen residents reviewed. The findings included: Resident #7 was admitted to the facility on January 22, 2010, with diagnoses including Hypertension, Dementia, Anxiety, Osteoporosis, Rhabdomyolysis, Esophageal Reflux, and Psychosis. Medical record review of the Minimum Data Set dated January 27, 2011, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 07 (severe impairment of cognition).	F 226	1. A new procedure was developed to ensure that the appropriate injuries are reported to the state agency. 2. A new investigation form and procedure have been developed as a method to more thoroughly investigate all potential injuries of unknown origin. 3. The Director of Nursing will conduct and/or supervise investigations for residents who experience potential injuries of unknown origin. The Social Services Director, who is also the abuse coordinator, will participate in these investigations. 4. The Administrator will sign off on all of these investigations and will report to the state agency any injury determined to actually be of unknown origin. All injuries determined to be of unknown origin will be reported to the QA Committee for help with resolution.	6/17/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy French | TITLE: Administrator | (X6) DATE: 05/20/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 Medical record review of the Nurse's Notes dated January 3, 2011, revealed "...During breakfast CNT (Certified Nursing Technician) informed me Licensed Practical Nurse (LPN #1) of a bruise to res. (resident's) rt. (right) finger. This nurse looked over...bruise to finger-greenish & (and) yellow in color (healing stage), eye glasses broken with lens missing & glasses taped together...Res. (Resident) also has a bruise (red in color) to right eye....RP (responsible party) contacted...was aware...noticed finger & also stated knew about glasses & I told (RP) LCSW (Licensed Clinical Social Worker) had them..." Continued medical record review of the nursing notes revealed an x-ray was ordered and completed on January 4, 2011, revealing a "...Swelling...Non-displaced fracture thru the base of the proximal phalanx second finger with probable extension into the MCP (Metacarpophalangeal) joint..." Review of the facility documentation dated January 3, 2011, revealed an incident of "unknown date and unknown time" had occurred revealing the "...res (resident) unable to state cause of injuries Rt. (right) eye bruised, pointer finger on rt. hand bruised...glasses broken & taped together..." Continued review of the facility documentation revealed the intervention "...In-service by PT. (Physical Therapy) regarding proper use of lifts and proper transfer techniques..." Medical record review of Nurse's Notes dated January 4, 2010 (? 2011) revealed CNT (#3) documented "...thought it happened on January 2, 2010 (? 2011) and...thinks it's occurring during	F 226		

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F 226	Continued From page 2 transfers with employees grabbing hands to get residents up..." Medical record review of Nurse's Notes dated January 4, 2010 (? 2011) revealed LPN #3 documented "...Noticed the bruise on (resident's) finger but...looked old and...thinks this is the same finger getting continuously bruised but doesn't know how it keeps happening..." Medical record review of the Nurse's Notes dated January 5, 2011, revealed CNT #2 documented " ...As of 1-1-11 Pt. (patient) didn't have a bruise on (resident), when...returned to work, while feeding Pt...noticed...finger was bruised...asked the nurse about it, and no one seem to know how it happened..." (Note - this nurse failed to report the injury to the facility staff after the CNT reported the incident.) Medical record review of the resident's plan of care dated February 2, 2011, revealed "...Use lifting device, draw sheet etc. to reduce shear..." Observation on May 5, 2011, at 8:45 a.m., revealed the resident seated in a Geri Chair with the foot rest in the up position, a geri sleeve on the left arm and the resident's speech was rambling and not understandable. Interview with Registered Nurse, Supervisor RN #2 on May 4, 2011, at 2:30 p.m., in the Library confirmed the resident sustained a fracture of unknown cause, unknown time; the resident's glasses were broken, and an investigation was not completed to determine the cause of the injury or damage to the resident's glasses. Interview with RN # 1 on May 5, 2011, at 12:45	F 226		

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F 226	Continued From page 3 p.m., in the Library confirmed the incident and injury of unknown origin was not reported to the state agency.	F 226	1. On 05/09/11, Resident #7 was examined by the facility optometrist. The facility mailed payment and ordered glasses on 05/12/11. 2. The Social Services Director created a form for the investigation of broken or missing resident items. 3. During an incident investigation, the investigator will document the current state of the item and how the item was broken. The family will be notified about the status of the item and this will be documented on the form. The form will be given to the Social Services Director who will then complete the investigation into the broken or missing item. The Social Services Director will document how and when the item will be repaired or replaced. Any family response to this investigation will also be documented on the form. Once completed, a copy of the form will stay with the incident investigation form. The other copy will be maintained in a binder in the Social Services office. 4. The Administrator will monitor 100% of these forms until no problems are identified for 3 consecutive months. After that time, the Administrator will conduct random checks of these forms for the next 3 months to ensure continued compliance.	6/17/11
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide services to meet the medical needs of one (#7) of fifteen residents reviewed. The findings included: Resident #7 was admitted to the facility on January 22, 2010 with diagnoses including Hypertension, Dementia, Anxiety, Osteoporosis, Rhabdomyolysis, Esophageal Reflux, and Psychosis. Medical record review of the Minimum Data Set dated January 27, 2011, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 07 (severe impairment of cognition). Review of the facility documentation dated January 3, 2011, revealed an incident of unknown date and unknown time had occurred revealing the "...res (resident) unable to state cause of injuries Rt. (right) eye bruised, pointer finger on rt.	F 250		

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F 250	Continued From page 4 hand bruised...glasses broken & taped together..." Observation on May 4, 2011, at 3:40 p.m., revealed the resident in a geri chair, with the lower extremities in the up position, the resident had one geri sleeve on the left arm, and the resident's speech was not understandable. Interview with the Social Worker on May 5, 2011, at 8:00 a.m., in the Social Worker's office, confirmed the Social worker had been made aware of the resident's broken glasses on Monday, January 3, 2011, and made the family aware of the same. Continued interview confirmed the family attempted to have the glasses repaired, by the resident's Optometrist, without success. Continued interview confirmed the facility had placed the resident on the Optometrist's list four to five weeks ago, to be seen at the facility and confirmed the resident had been without glasses for four months.	F 250		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280	1. On 5/3/11, the CNA Care Plan for Resident #1 was updated to reflect the NPO status. 2. On 5/17/11, all residents' CNA Care Plans were reviewed to ensure dietary status accuracy. 3. The MDS Coordinator will update the CNA Care Plans with new diet orders as these orders are received. 4. The MDS Coordinator will monitor CNA Care Plans weekly to ensure NPO status is accurate. The DON will audit CNA Care Plans monthly until no issues are identified with NPO status for 3 consecutive months.	6/17/11

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F 280	Continued From page 5 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of the Certified Nurse Aide (CNA) resident care plan and the care plan, and staff interview, the facility failed to revise the care plan to address the nothing by mouth status for one (#1) of fifteen residents reviewed. The findings included: Resident #1 was admitted to the facility on March 17, 2005, with diagnoses including Cerebral Palsy, Osteoporosis, and Mental Disorder. Medical record review of the physician's telephone order dated February 16, 2011, and the 2011 March and April Recapitulation Order revealed "NPO (nothing by mouth)." Further medical record review revealed the NPO was a dietary recommendation due to episodes of vomiting. Observation on May 3, 2011, at 2:20 p.m., revealed the resident in a wheelchair by the nursing station across from the third floor dining room. Further observation revealed facility staff serving ice cream to residents in the third floor dining room. Continued observation revealed at	F 280		

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F 280	Continued From page 6 2:40 p.m., Licensed Practical Nurse (LPN) #3 fed ice cream to resident #1. Medical record review of the care plan with problem onset date of February 22, 2011, revealed the resident was dependent on tube feeding for hydration and nutritional support and was at "High risk for aspiration...is NPO..." Further review revealed an approach of "...avoid food related activities..." Review of the undated CNA Resident Care Plan revealed "...Diet: tube feeder w/ (with) pleasure feeding..." Further review revealed "...Comments: (Resident) enjoys thickened coffee and treats at times but gets...nutrition fed by the nurse..." Interview with the Minimum Data Set (MDS) nurse on May 3, 2011, at 2:45 p.m., in the MDS office, confirmed the CNA care plan had not been revised to address the NPO status. Interview with the resident's direct care CNA #4, on May 3, 2011, at 3:17 p.m., in the hall outside the resident's room, revealed the CNA had been informed by a nurse not to give anything to the resident by mouth "...since the end of February..."	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	F 281		

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F 281	Continued From page 7 and interview, the facility failed to follow the physician order for one (#1) of fifteen residents reviewed. The findings included: Resident #1 was admitted to the facility on March 17, 2005, with diagnoses including Cerebral Palsy, Osteoporosis, and Mental Disorder. Medical record review of a physician's telephone order dated February 16, 2011, and the 2011 March and April Recapitulation Order revealed "NPO (nothing by mouth)." Further review revealed the NPO was a dietary recommendation due to episodes of vomiting. Observation on May 3, 2011, at 2:20 p.m., revealed the resident in a wheelchair by the nursing station across from the third floor dining room. Further observation revealed facility staff serving ice cream to residents in the third floor dining room. Continued observation revealed at 2:40 p.m., Licensed Practical Nurse (LPN) #3 fed ice cream to resident #1. Interview on May 3, 2011, at 2:40 p.m., at the third floor nursing station, with LPN #3, confirmed the physician's order was for nothing by mouth.	F 281	1. On 5/3/11, the nursing department was in-serviced regarding the NPO status for Resident #1. On 5/9/11, NPO signage was placed on Resident #1's door, on his wheelchair and on his Medication Administration Record. The nursing department was in-serviced on 5/9/11 regarding the placement of NPO signage for Resident #1. 2. All residents with NPO status will have appropriate signage placed on the resident's door, on her/his mobility device and on her/his Medication Administraton Record. 3. The nursing staff will receive in-service training when new NPO status orders are received. 4. The QA CNT or QA Nurse will audit NPO signage weekly. Problems will be brought to the DON for resolution.	6/17/11
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain dietary equipment in a sanitary manner. The findings included: Observation on May 3, 2011, beginning at 10:08 a.m., with the Certified Dietary Manager (CDM) present, in the dietary department revealed the following: 1. The ceiling vent, by the hallway door, had a heavy black accumulation of debris in the grate. 2. The interior surface of the tilt skillet had a sticky accumulation of debris and dried noodles present. 3. The filters in the hood had dust accumulation present. 4. The grill surface had a heavy black accumulation of debris. 5. The large black floor fan, not in operation, by the three compartment sink, fan blades had black debris present. 6. The ceiling surface of the walk-in refrigerator had an accumulation of dust by the condenser unit. Interview with the CDM on May 3, 2011, beginning at 10:08 a.m., in the dietary department, confirmed the ceiling vent had an accumulation of debris; the tilt skillet interior	F 371	#1 1. The ceiling vent grate was cleaned by the maintenance assistant on 5/3/11. 2. Dietary equipment will be maintained in a sanitary manner. Food will be stored, prepared and distributed at all times under sanitary conditions. 3. The ceiling vent grate will be cleaned monthly by the maintenance assistant. 4. This corrective action will be monitored by the department CDM,CFPP. The RD will check the ceiling vent grate during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring. #2 1. The tilt skillet was cleaned by the dietary staff on 5/3/11. 2. Dietary equipment will be maintained in a sanitary manner. Food will be stored, prepared and distributed at all times under sanitary conditions. 3. The tilt skillet will be added to the dietary daily cleaning task assignment. 4. This corrective action will be monitored by the department CDM,CFPP. The RD will check the tilt skillet during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring.	6/17/11 6/17/11

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain dietary equipment in a sanitary manner. The findings included: Observation on May 3, 2011, beginning at 10:08 a.m., with the Certified Dietary Manager (CDM) present, in the dietary department revealed the following: 1. The ceiling vent, by the hallway door, had a heavy black accumulation of debris in the grate. 2. The interior surface of the tilt skillet had a sticky accumulation of debris and dried noodles present. 3. The filters in the hood had dust accumulation present. 4. The grill surface had a heavy black accumulation of debris. 5. The large black floor fan, not in operation, by the three compartment sink, fan blades had black debris present. 6. The ceiling surface of the walk-in refrigerator had an accumulation of dust by the condenser unit. Interview with the CDM on May 3, 2011, beginning at 10:08 a.m., in the dietary department, confirmed the ceiling vent had an accumulation of debris; the tilt skillet interior	F 371	#5 1. The floor fan was cleaned by dietary staff on 5/3/11. 2. Dietary equipment will be maintained in a sanitary manner. Food will be stored, prepared and distributed at all times under sanitary conditions. 3. The floor fan will be cleaned weekly and checked daily for any debris before operating. 4. This corrective action will be monitored by the department CDM,CFPP. The RD will check the floor fan during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring. #6 1. The ceiling surface of the walk-in refrigerator was cleaned by dietary staff on 5/3/11. 2. Dietary equipment will be maintained in a sanitary manner. Food will be stored, prepared and distributed at all times under sanitary conditions. 3. The ceiling surface of the walk-in refrigerator will be cleaned two times each week, on the days that stock is delivered. 4. This corrective action will be monitored by the department CDM,CFPP. The RD will check the ceiling of walk-in during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring.	6/17/11 6/17/11

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F 371	Continued From page 9 surface had sticky debris and dried noodles present; the hood filters had dust accumulation; the unused grill surface had a build-up of black debris; the large floor fan blades had black debris present; and the walk-in refrigerator ceiling surface had dust present.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	1. On 5/17 and 5/18/11, the QA Nurse in-serviced nursing staff regarding infection control and hand washing procedures. 2. Nursing staff will be required to use appropriate infection control procedures regarding hand washing and use of gloves. 3. The QA Nurse will continue to in-service nursing staff on proper infection control and hand washing/glove use. 4. Quarterly, the QA Nurse will observe care and complete a checklist for all nursing personnel regarding hand washing and glove use. All new nursing department employees will be checked off on hand-washing and glove use within one week of hire. Employees who experience problems during this procedure will receive additional training/observation by the Director of Nursing.	6/17/11

MAY 23 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44A114	A. BUILDING _____ B. WING _____	05/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE HEARTLAND	3025 FERNBROOK LANE NASHVILLE, TN 37214

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F 441	Continued From page 10 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to maintain infection control for one (#9) of fifteen residents reviewed. The findings included: Resident #9 was admitted to the facility on May 20, 2009, with diagnoses including Diabetes, Hypertension, and Dementia. Review of the Minimum Data Set dated August 21, 2010, revealed the resident was incontinent of bowel and bladder and totally dependent for activities of daily living. Observation on May 4, 2011, at 10:15 a.m., in the resident's room, revealed CNA #1 (certified nursing assistant) had provided incontinence care to the resident. Continued observation revealed the CNA had used gloves to provide the care, using the same gloves, the CNA pulled the resident pants on, adjusted the mechanical lift's control knob, removed the lift sling from behind the resident, placed the personal alarm on the resident, opened the dresser drawers, and nightstand drawer, to place personal items in the drawers.	F 441		

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F 441	Continued From page 11 Review of the facility's policy "Perineal Care" revealed "...12. Remove gloves and discard into designated container. Wash and dry your hands thoroughly..." Interview with CNA #1 on May 4, 2011, at 10:25 a.m., in the hallway, confirmed had not removed gloves or disinfected hands after providing incontinent care to the resident. Interview with the Director of Nursing on May 5, 2011, at 8:55 a.m., in the hallway, confirmed gloves are to be removed and hands disinfected after providing incontinent care.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of discharge summaries, and interview, the facility failed to have a physician signature on two resident discharge summaries (#14, #15) of two	F 514	#1 1. The physician will sign off on all resident discharge summaries. 2. All discharge summaries will be reviewed and signed by the physician. 3. The Director of Nursing will place the discharge summary in the file for the physician's review and signature. After completion by the physician, the discharge summary will be maintained in the discharged medical record. 4. For the next 3 months, the Administrator will monitor the medical record of all discharged residents to ensure the discharge summary is signed by the physician. If no exceptions are identified, this monitoring will cease.	6/17/11

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F 514	Continued From page 12 resident discharged records reviewed; and failed to maintain accurate and organized clinical record information. The findings included: Resident #14 was admitted to the facility on March 30, 2007, with diagnoses including Benign Hypertension, Presenile Dementia, Aphasia, Benign Neoplasm Prostate, and Mixed Incontinence. Continued medical record review revealed the resident expired on November 10, 2010, at 1:55 a.m. Review of the Discharge Summary, "Physician Documentation Required" which showed the Cause of Death, was not documented and the Physician had not signed the Discharge Summary. Interview with the facility Administrator on May 5, 2011, at 12:20 p.m., in the library, confirmed the physician had not signed the discharge summary. Resident #15 was admitted to the facility on February 21, 2010, with diagnoses including Dementia without Behavior, Chronic Pain, Chronic Skin Ulcer, Stress Incontinence, Urinary Retention, and Hypertension. The resident was discharged from the facility to the hospital on September 27, 2010, for additional antibiotic therapy for a urinary tract infection. The resident was transferred to another long term care facility on October 6, 2010, after being discharged from the hospital. Medical record review of the discharge summary	F 514		

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F 514	Continued From page 13 revealed the admission date of February 21, 2010, and the discharge date of October 6, 2010. Further medical record review revealed a section entitled "Physician Documentation Required" that was not filled out and had no physician signature. Interview with the facility Administrator on May 5, 2011, at 12:20 p.m., in the library, confirmed the physician had not signed the discharge summary. Review of narcotic destruction logs revealed the destruction logs had prescription number and amount of the drug to be destroyed. Medcial record review of the individual resident controlled substance sheets revealed the sheets were thrown into a large brown box for storage. Continued medical record review revealed the sheets were unorganized and difficult to match the controlled substance sheets to the correct prescription number on the destruction medication log. Interview with the MDS Coordinator (Minimum Data Set) and the DON (Director of Nursing) on May 4, 2011, at 10:30 a.m., in the library, confirmed this was the facility's method of organization of storage of the individual resident controlled substance sheets for the destruction of the medication log. C/O #27880	F 514	#2 1. The residents' medical records will be maintained in an accurate and organized manner. 2. The individual resident controlled substance sheets will be maintained on the medical record in an organized manner. 3. After destruction of narcotics, the completed controlled substance sheets will be placed on each resident's medical record. 4. For the next three months, the QA Nurse will monitor the medical records for appropriate controlled substance sheets. If no exceptions are identified, this monitoring will cease.	6/17/11

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